Michigan Legal Services

Anti-poverty Advocates

June 5, 2009

# Michigan Legal Services Position on Health Care Reform Bills in the Senate and House

## Introduction:

Michigan Legal Services applauds the efforts by the House and Senate leadership to enact comprehensive health care reform. MLS has been advocating for some time that reform might best be centered on a catastrophic coverage system and we are gratified that both houses, and leaders from each political party, have presented plans that center on catastrophic coverage. This letter is MLS's official position on the 14 bills presently pending in the Senate and House – SB 579 through 582 and HR 4934 through 4943. Because these bills may change as the legislative process continues, we will discuss the concepts included in these bills and not use the applicable bill number.

We appreciate the amount of work that went into these proposals – and the amount of work yet to come. The health care finance and delivery system is so dysfunctional that each dollar in the system supports one or more stake holders, and makes crafting any sort of reform difficult. Having all stake holders at the table to craft these bills was, and remains, crucial to creating a final product. We are grateful to Sen. George and Rep. Corriveau for their work and hope we can continue to work together to create a final product that will be good for Michigan's people.

## Catastrophic Coverage

Both recommend the same catastrophic coverage funding mechanism and almost identical payment structures. The funding mechanism also meets one of our goals as advocates – using 'recycled' funds and not raising new premiums, fees, taxes or other revenue enhancements. Requiring insurers to share the risk equally for these catastrophic claims is a wise choice.

Both plans would cover claims over $25,000 though the Senate Bill caps the claims at $250,000. We believe the differences are easily reconcilable and support passage of a catastrophic claims program consistent with those presented in these proposals.

MLS does not favor the capped version but views it as a minor problem since the catastrophic claims organization established would be able to buy re-insurance to cover amounts over the $250,000 limit.

MLS also does not favor the Senate provision that only 90% of claims would be covered between $25,000 and $250,000. We understand the rationale is to make sure insurance companies do not simply pay claims in order to get to the catastrophic coverage quickly. This "skin in the game" theory makes sense superficially.

However, the financing mechanism for the catastrophic coverage program is based on assessing insurers a fee based on how much is spent on catastrophic coverage. The more the insurers spend, the higher their assessments. That means that insurers already have "skin in the game." A second provision with the same effect – the 90% payment provision – appears to be unnecessary.

Our concern is that if neither the health insurance nor the catastrophic claims organization covers that unpaid 10% - which can amount to $22,500 under the 'capped' version – the individual policy holder would be forced to forego treatment or go into debt and possibly bankruptcy. This provision seems to us to be the result of health insurers lack of trust in each other and would negatively affect consumers of care. We would ask that the catastrophic claims system pay 100% of all claims as long as the financing mechanism is based on assessments to the insurance companies.

**Ending discrimination against the sick and injured**

Probably the worst feature of our insurance system is that those who have pre-existing conditions, or those who become ill or injured, are treated differently than those who are healthy. The sick and injured can be denied coverage completely. These practices are unconscionable and must be ended. With the enactment of catastrophic coverage that spreads risk evenly among all insurers – there is no more economic justification for practices that discriminate against the sick and injured.

We strongly support the provisions that guarantee re-issue and end or limit the practice of denying people coverage when they have a pre-existing condition. Premium limitations present in both sets of bills are also important reforms.

These reforms alone, with the passage of the catastrophic coverage legislation, will transform the way health insurance is marketed and administered in Michigan. The geographic limits on premiums are important adjuncts to these provisions.

We prefer that every insurer in the state be required to use statewide community rating. But the provisions for those smaller companies that do not have a statewide 'scope of operations' seem reasonable to us.

We also believe that discrimination based on gender should simply be outlawed. At least one of the sets of proposals does that explicitly. We suggest it be included in both versions. This issue of banning discrimination against women in premium setting should not be controversial.

**Greater access to coverage**

If catastrophic reinsurance coverage is enacted, premiums for health insurance should drop. In the Senate version there is language that at least encourages a reduction in premiums. The House version includes an extensive reporting structure clearly designed to monitor premiums, among other things. That reduction in premium should allow more people to purchase insurance. But both houses of the legislature are considering plans that would 'recycle' funds already in the system in order to provide much greater access to private health coverage.

Providing complete subsidies to those at or below 200% of FPL and partial subsidies to those between 200% and 300% of FPL is in both sets of bills. Until we have the resources to cover everyone, MLS supports this scheme. It may cover up to 500,000 lives and significantly reduce the number of uninsured people in the state.

Both plans contain a proposed fee on not-for-profit health insurers that would equate to the amount each of them would pay were they 'for-profit corporations.' It is unclear to us how much revenue this would produce and we question whether it is adequate to cover everyone up to 300% of FPL if it stood alone. Both proposals include other income streams, however.

Another way to 'recycle' funds is included in the House version and is strongly supported by MLS. Setting minimum 'loss ratios' requires health insurers to use more of the premium dollar for actual medical care and less for administrative overhead and other non-medical expenses. We would suggest that 'medical loss ratio' limitations be included in the Senate plan.

We do not see why all income streams in these proposals should not be enacted in order to increase subsidies for insurance and to provide for an increased number of primary care providers. We support a funding stream that includes the following:

1. "Not for profit" fee mentioned above; and
2. Up to a 1.8%, or other acceptable amount, surcharge on medical costs paid by insurers; and
3. Cost shifting to aid seniors; and
4. Medicaid waivers, as needed; and
5. Limitations on 'loss ratios;' and
6. Use of QAAP funds, as needed.

We are confident that with all these streams of funding, most of which are 'recycled money' as in the catastrophic coverage proposals, we could cover hundreds of thousands

of Michiganders. Perhaps with the coming Federal reform Michigan could be the first state to have everyone covered.

The Senate version guarantees providers "Medicare fees." We see this as an access provision that we support. Without adequate fees in the system providers cannot participate and give people the care they need. We suggest this provision be included in both the House and Senate proposals. Because of the Massachusetts experiment's lessons in increasing costs after enacting their own access expansion, we suggest that Medicare fees also be made the top limit that may be charged under the enacted program.

The two sets of proposals contain somewhat different benefit packages. The packages are developed in different manners as well. We believe that the benefit package should equate to what is presently provided under Medicaid as closely as possible. The two (2) proposals leave us a little confused as to what is actually covered and what is not. We suggest more thought and more work go into clear definitions of what will be provided. We do not want to see a major access to care increase which leaves out key components such as mental health or behavioral care.

We do not support the "anti-crowd out" provision that requires an applicant be uninsured for 6 months before he or she would be eligible for coverage under the enhanced access program. Our main objection is that it would leave individuals, and families, without coverage for a significant amount of time before insurance would be available. Chronic illnesses would worsen and by the time the 6 months was up the cost of care would be higher and the individual sicker. We appreciate the 3 exceptions to the rule written into the Senate bill but believe the concept is flawed and this sort of 'anti-crowd out' proposal should be removed.

The schemes for greater access proposed rely on the private insurance industry to provide coverage anyway. If an employer decides to cancel a policy due to cost and the employee remains on the payroll, that employee would be ineligible for subsidies for 6 months even though the employee would be going through a private health insurer sanctioned by a board or the state. It is unlikely that small employers would end insurance benefits any more rapidly than they are already doing because of costs. We believe this 6 month wait is unnecessary and unwise.

**Patient safety and cost saving provisions**

Both proposals contain some cost saving provisions and both would focus funds on primary and preventive care, which should, in the long run, create a more effective system economically and medically. We believe all these provisions should be enacted;

1. Values based prescribing;
2. Values based medicine with outcome driven provider payments;
3. Electronic prescribing; and
4. Wellness incentives.

All these are important to transforming the health care system into one that gives better value for the premium dollars spent.

**Other proposals**

The Gold Benefit Prescription plan would provide great savings to every Michigander without prescription drug coverage. This would lower costs and improve medical care, especially for those with chronic conditions. We believe in this plan and have long supported the 'bulk purchasing' of prescription drugs as a means of increasing access to a major therapy – pharmaceutical drugs – and of lowering the cost of care.

One problem not addressed by either plan is the shortage of primary care providers. It is this problem that causes us to suggest using every funding stream possible. The Massachusetts experiment taught two important lessons. First, there were not enough primary care providers to actually provide health care once insurance coverage was expanded dramatically. Second, costs went up in the first year much more than the national average. [Costs appear to be better controlled in Massachusetts now – 3 years later - since they were actually able to lower premiums slightly this year.]

We ask for the development of a program to encourage care givers to become primary care givers. Part of the program is implied in the access plans where primary care will be emphasized and provider fees would reflect that emphasis. A program to forgive educational loans to newly graduated doctors or other primary care providers would certainly help. We make no specific recommendation other than that once an access bill is passed the very next problem that must be addressed is the supply of medical professionals to actually do the work. We call on both houses to recognize this problem and to make a commitment to finding and enacting a solution.

**Conclusion**

We at MLS are very encouraged that leadership in both political parties and both legislative chambers are so close to working out a program that may transform healthcare finance and delivery in Michigan. Most of our suggestions and our observations of differences should not be 'deal breakers' for either side.

It would be a great tragedy of after this auspicious beginning the move toward a more just health care finance and delivery system failed. We intend to work to make sure that there is no failure. We intend to work to make sure that both houses and both political parties can equally claim credit for a newly transformed health care delivery and finance system. The people of Michigan are watching these developments and will certainly support those who work collaboratively to try and solve the health care crisis.

We hope that by the end of the year significant legislation will have been passed.